F. Provider Documentation

F. Provider Documentation

Medicaid requires documentation be maintained to verify that providers have the appropriate qualifications. Documentation is also required for each service that is provided. The following section outlines the different types of documentation and the requirements. All documents must be completed and signed in ink.

By signing the documentation the provider is certifying that the information is true and accurate.

PROVIDER CERTIFICATION

Providers whose services are billed at the professional level must sign a Provider Certification Agreement. In addition, a copy of their valid license must be on file for all time periods billed. For a SLP this would include a copy of their CCC or equivalent documentation (see Billable Services Section pg 2). By signing a Provider Certification Agreement, providers are relinquishing their right to bill Medicaid directly for services provided in accordance with an IEP.

To complete the Provider Certification, the professional staff member enters his or her name and title then checks the professional category under which he or she qualifies. The staff member then completes either Section A or B on the back of the form based on their ability to bill Medicaid. The staff member then signs the form and gives it to the Medicaid clerk. The form remains valid as long as the staff member continues in the same position within the supervisory union or until the person has a name change. The supervisory union representative signs the form, which can be the superintendent, special education director or a designee. The Medicaid clerk maintains the signed form and the copy of the provider's license.

CASE MANAGEMENT ASSURANCE FORM

The form is completed by the case manager to document the actual amount of case management provided. The student and provider information needs to be completed at the top of the form. The IEP initiation date needs to be completed. The initiation date of all IEP's and amendments being billed must be listed. The number of case management hours listed in the IEP(s) and amendments must be indicated on the form. If the case management on the IEP is written as a monthly service, that is how the time should appear on the case management assurance form indicating the hours are monthly. The form is completed each billing period.

The assurance form needs to include the beginning and ending dates of the billing period as well as the actual hours of case management provided. This number should reflect the total hours provided during the billing period. If the student enters or exits the district during the billing period, the "to" and "from" dates should reflect the actual dates of service. Do not include time spent for the coordination and development of the IEP and evaluation process on the case management assurance form. This case management time is billed as an IEP or evaluation claim. The case manager signs and dates the form and submits it to the Medicaid clerk.

PROVIDER DOCUMENTATION FOR EACH OCCURRENCE OF SERVICES

The School-Based Health Services Program requires documentation for each occurrence of service. The documentation is required due to audit findings by the Office of Inspector General in its review of School-Based Health Services Programs in other states. This is a general documentation requirement of Medicaid that needs to be met for the school services billed under the LOC process.

DEVELOPMENTAL & ASSISTIVE THERAPY SERVICE DOCUMENTATION LOG

The form is to be completed by the individual service provider to document each service that he or she is providing. If a student has more than one developmental and assistive therapy service, a form needs to be completed for each service. If the same IEP service is delivered by more than one provider, then each provider needs to complete a separate documentation log. A separate form is completed for each billing period. If the documentation is not available, the service cannot be included on the LOC claim.

The student and provider information needs to be completed at the top of the form. The provider also indicates the specific IEP activity, group size, frequency and duration being provided. The IEP activity on the Developmental and Assistive Therapy log needs to read exactly like the IEP. It is acceptable to truncate, abbreviate, etc… as long as there is no doubt as to which IEP service is being documented. The group size, minutes per session, sessions per week and hours per week can be based on the IEP or what is actually being provided.

In the calendar an X can be marked to indicate the service provided equals the amount of time and group size listed in the Minutes Per Session and Individual or Group boxes on the Developmental and Assistive Therapy log. If the minutes per session or group size are different the actual minutes per session or group size should be indicated on the calendar. It is acceptable to mark more than one X in a box if a service is provided more than once a day. If the minutes per session or group size are different than what is listed on the Developmental and Assistive Therapy log, the actual minutes per session or group size should be indicated. Providers have the option to indicate the amount of time provided instead of utilizing an X.

Mark an X for each day that the services were provided for the minutes and group size indicated in the Minutes Per Session box and the group size listed in the Individual or Group box. Each provider is allowed to document services they provide as well as those provided by substitutes who fill in on a temporary basis. At the end of the billing period, the service provider calculates the hours of billable service provided during the billing period. Total hours are broken out between one-on-one and small group. The provider signs and dates the form.

Once the form is signed, it goes to the professional who is responsible for supervising that service. The professional needs to sign, print their name and date the form. No supervisor's signature is required for staff members who are considered professionals for Medicaid billing. The documentation form needs to be submitted to the Medicaid clerk.

PERSONAL CARE SERVICE DOCUMENTATION LOG

The form is to be completed by the staff person providing the majority of these services. If services are evenly split between two people, both individuals should sign the form. Multiple Personal Care Service Documentation Logs can only be completed when the student has two or more full-time aides. A separate form is completed for each billing period.

In order for a service to be billed as personal care, the student's IEP must require one-on-one services for the entire school day. This may be listed as one service on the IEP or a combination of one-on-one services that total the student's entire school day. Services may be provided by staff other than the personal care aide. The personal care aide must be providing at least one of the one through nine activities listed under the service types on the form. If those requirements are met, the provider can bill full-time as a personal care aide even though some of the services

he or she provides may fall under developmental and assistive therapy or a related service category.

The student and provider information needs to be completed at the top of the form. The Personal Care Hours Per Week line must reflect the number of hours in the student's school week. If in addition, the student receives personal care on the bus, a note should be placed on the log indicating this and the amount of time service is provided. This note should be placed below the Personal Care Hours Per Week line. The provider also indicates the types of service being provided from the list at the bottom of the form. The provider records the number of hours personal care was provided each day in the calendar (including bus time). The provider is allowed to document services they provide as well as those provided by substitutes who fill in on a temporary basis.

The total hours personal care service was provided during the billing period is calculated and entered in the appropriate box. The provider signs and dates the form. Once the form is signed, it goes to the professional who is responsible for supervising that service. The professional needs to sign, print their name and date the form. There can only be one personal care documentation log per billing period unless the student has multiple full-time aides. The documentation form needs to be submitted to the Medicaid clerk.

RELATED SERVICES DOCUMENTATION LOG

Service providers can use documentation records designed for their profession as long as all the required elements for Medicaid billing are included, or use the Related Services Documentation Log. A separate form is completed by each provider for each billing period.

The student and provider information needs to be completed at the top of the form. For each day on which services are provided to the student, the date is entered and a brief description indicating what activity or service was provided. The description needs to be more detailed then the name of the related service, with the exception of counseling. In the next column, the service provider needs to indicate whether the services were provided one-on-one or in a small group. An "I" for individual or "G" for small group should be entered for each day he or she provided Medicaid billable services to the student. Small group is considered six or less students for a professional and four or less students for a paraprofessional. The total one-on-one and small group hours are totaled and entered at the bottom of the form.

At the end of the billing period, the service provider signs the form. The provider is allowed to document services he or she provides as well as those provided by substitutes who fill in on a temporary basis. The provider signature should be the person providing the majority of the services during the month being billed. Once the form is signed, it goes to the professional who is responsible for supervising that service. The professional needs to sign, print their name and date the form. A supervisor's signature is not required for staff members who are considered professionals for Medicaid billing.

When services are being provided under the direction of a PT/OT/SLP, the student's case manager needs to sign the form to verify that the services were provided. The name of the PT/OT/SLP who developed the plan must be noted on the form.

The documentation form is submitted to the Medicaid clerk.

PROGRESS NOTES

Progress notes are required for all related services billed to the School-Based Health Services Program. Progress notes can be the goals/objectives section of the IEP, a typed or handwritten note or a description of the student's progress.

Progress notes need to be completed quarterly or to coincide with the school marking period. If a progress note is not completed, future billing for the service can not be submitted. If it is discovered that a service has been billed and progress notes were not completed, the service will need to be removed from the Level of Care Form and the claim adjusted accordingly.

CLERK RESPONSIBILITIES FOR PROVIDER DOCUMENTATION

- All header information is completed
- Developmental and Assistive Therapy log—the IEP Activity matches the IEP Service Description
- Developmental and Assistive Therapy log —each log contains only one IEP service performed by one provider
- Case Management Assurance form—the IEP initiation/amendment date matches the IEP
- Case Management Assurance form —the hours per week/month match the IEP for each IEP/amendment
- Case Management Assurance form —the from and to dates do not exceed the dates billed on the LOC
- Related Services log—there is a complete date, service description, group size and time for each service
- Related Services log—the service description is adequate
- Personal Care log—calendar includes time not X's
- Personal Care log—only one log per student, unless there are two full-time personal care aides
- Total hours must match the documentation
- If the documentation indicates services on a snow day/vacation/weekend etc… the clerk can only bill for services provided when school was in session. Best practice is to place a note in the margin of the documentation log indicating the amount of time that will be billed on the LOC
- The documentation log is completed in ink and does not include white-out. Logs containing white out or completed in pencil need to be photocopied or the clerk needs to obtain a new log
- Hand changes to the documentation log need to be initialed where appropriate
- The provider has signed and dated the log
- The provider listed in the header is the individual signing as provider
- A professional has signed and dated the log where applicable
- The professional's printed name appears on the log where applicable and matches the name of the individual who signed as professional
- For logs signed electronically, the provider's printed name, date and submitted electronically check box are completed electronically
- All documentation logs are completed on the correct version of the form

PROVIDER CERTIFICATION/AGREEMENT/REASSIGNMENT OF PAYMENT
For Providers of School-Based Health Services

Under Federal regulations, in order for a supervisory union to bill Medicaid for services furnished by a provider who is under contract or agreement with the supervisory union, the provider must (1) meet Medicaid provider qualifications, (2) have a Provider Agreement with the State Medicaid Agency, and (3) reassign his/her right to Medicaid Payment for such services to the supervisory union.

Provider Qualifications

I, _____Marion Abair_____ ____Case Manager_____
Name Title

certify that I am: (Please check all that apply)

_____ Currently enrolled as a Medicaid Provider (Provider #_____)
Sign Section A on reverse.

__X__ Licensed by the State of Vermont (Please attach a copy of license.)
Sign Section B on reverse.

_____ Certified by the Vermont Department of Education (Please attach a copy of certification)
Sign Section B on reverse.

_____ A graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association. (Please attach a copy of the degree).
Sign Section B on reverse.

_____ Have a Certificate of Clinical Competence from the American Speech and Hearing Association or the equivalent education and work experience to qualify for such Certification. (Please attach a copy of the Certificate or proof of qualifications.)
Sign Section B on reverse.

_____ Registered by the American Occupational Therapy Association. (Please attach a copy of Registration.)
Sign Section B on reverse.

_____ Have a Master's Degree from an accredited School of Social Work. (Please attach a copy of the Degree.)
Sign Section B on reverse.

_____ Other Qualifications: (Please specify)
Sign Section B on reverse.

Revised: July 2006 (over)

A. Reassignment of Payment

I hereby voluntarily reassign my right to payment from the Medicaid agency for services I provide to students under my agreement with the _____Supervisory Union.

_____ _____ _____
Signature of Provider Title Date

_____ _____
Signature of Supervisory Union Representative Date

Sign either A or B

B. This section applies to providers not otherwise enrolled in the Medicaid Program.

As a condition for providing services to Medicaid eligible children I agree to the following:

1. To conform to all applicable Federal and State laws and regulations.
2. To offer services in accordance with Title VI of the 1964 Civil Rights Act and Section 504 of the Rehabilitation Act of 1973, as amended.
3. To keep such medical, case or business records as are necessary to fully document the extent of services provided and to furnish these records to the State Medicaid Provider Fraud Unit of the Office of the Vermont Attorney General, if requested to do so.

I understand that this Provider Agreement does not allow me to bill Medicaid directly for Services I may furnish to Medicaid recipients.

Marion Abair Case Manager 9/1/02
Signature of Provider Title Date

Lauran Abott 9/1/02
Signature of Supervisory Union Representative Date

Revised: July 2006

PROVIDER CERTIFICATION/AGREEMENT/REASSIGNMENT OF PAYMENT
For Providers of School-Based Health Services

Under Federal regulations, in order for a supervisory union to bill Medicaid for services furnished by a provider who is under contract or agreement with the supervisory union, the provider must (1) meet Medicaid provider qualifications, (2) have a Provider Agreement with the State Medicaid Agency, and (3) reassign his/her right to Medicaid Payment for such services to the supervisory union.

Provider Qualifications

I, _____ _____
Name Title

certify that I am: (Please check all that apply)

_____ Currently enrolled as a Medicaid Provider (Provider #_____)
Sign Section A on reverse.

_____ Licensed by the State of Vermont (Please attach a copy of license.)
Sign Section B on reverse.

_____ Certified by the Vermont Department of Education (Please attach a copy of certification)
Sign Section B on reverse.

_____ A graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association. (Please attach a copy of the degree).
Sign Section B on reverse.

_____ Have a Certificate of Clinical Competence from the American Speech and Hearing Association or the equivalent education and work experience to qualify for such Certification. (Please attach a copy of the Certificate or proof of qualifications.)
Sign Section B on reverse.

_____ Registered by the American Occupational Therapy Association. (Please attach a copy of Registration.)
Sign Section B on reverse.

_____ Have a Master's Degree from an accredited School of Social Work. (Please attach a copy of the Degree.)
Sign Section B on reverse.

_____ Other Qualifications: (Please specify)
Sign Section B on reverse.

(over)

A. Reassignment of Payment

I hereby voluntarily reassign my right to payment from the Medicaid agency for services I provide to students under my agreement with the _____Supervisory Union.

_____ _____ _____
Signature of Provider Title Date

_____ _____
Signature of Supervisory Union Representative Date

Sign either A or B

B. This section applies to providers not otherwise enrolled in the Medicaid Program.

As a condition for providing services to Medicaid eligible children I agree to the following:

2. To conform to all applicable Federal and State laws and regulations.

2. To offer services in accordance with Title VI of the 1964 Civil Rights Act and Section 504 of the Rehabilitation Act of 1973, as amended.

3. To keep such medical, case or business records as are necessary to fully document the extent of services provided and to furnish these records to the State Medicaid Provider Fraud Unit of the Office of the Vermont Attorney General, if requested to do so.

I understand that this Provider Agreement does not allow me to bill Medicaid directly for Services I may furnish to Medicaid recipients.

_____ _____ _____
Signature of Provider Title Date

_____ _____
Signature of Supervisory Union Representative Date

VERMONT APPROVED EDUCATOR ENDORSEMENT CODES

Each license must have one or more endorsements. An endorsement specifies the instructional level and the endorsement content area in which the license holder is authorized to perform educational services. The first digit in an endorsement code denotes the grade or age range the educator may service, and the latter two digits denote the content area. (Example: 2-05 = Grade 7-12 English)

Instructional Levels

Some instructional levels are restricted to specific endorsements. Please refer to the endorsement competencies and endorsement authorization statement (located under the endorsement name) for the instructional levels available for the endorsement. Note: Not all instructional levels can be assigned to all endorsements.

Code	Range	Restrictions
0	Birth through Grade 3	Early Childhood Education only
1	Grades K-6	Elementary Education only
2	Grades 7-12	No restriction
3	Grades PreK-12	No restriction
4	Grades 5-9	Middle Grades only
5	Ages 3 through age 6	Early Childhood Special Educator only
6	Ages 3 through Age 21	Education Speech Language Pathologist, Director of Special Education, Teacher of the Blind and Visually Impaired, Teacher of the Deaf and Hard of Hearing, and Intensive Special Education only.
7	Grades PreK through 6	Not available for English, Social Studies, Mathematics, Science, middle Grades
8	Grades K-8	Special Educator and Consulting Teacher only
9	Grades 5-12	Family and Consumer Science, and Design and Technology Education only
10	Grade 7 through age 21	Special Educator, consulting Teacher, and Adult Services Coordinator
11	Grade 9 through 12	Trades and Industry, Technical Professional and those marked with "*" only
12	Grades K through age 21	Special Educator, Consulting Teacher

Endorsement Content Areas

00 Elementary Education
01 Agriculture, Food and Natural Resources
02 Art
03 Business and Administration
04 *Business and Administration in Career and Technical Centers
05 English
06 Modern and Classical Languages:
- A. French
- B. Spanish
- C. German
- D. Russian
- E. Latin
- F. Greek

08 Physical Education
09 Family and Consumer Sciences
10 Design and Technology Education
11 Mathematics
12 Music
13 Science
14 Computer Science
15 Social Studies
17 *Trades and Industry
18 *Technical Professional
19 Middle Grades
30 Driver Education
31 Health Education
32 *Occupational Family and Consumer Sciences
34 *Health Services
35 *Marketing and Sales Services
36 Early Childhood Education
37 Theatre Arts
38 Dance
39 Bilingual Education
40 English as a Second Language
42 Educational Technology Specialist
54 School Social Worker
60 *Cooperative Career and Technical Education
61 Library Media Specialist
64 School Counselor
65 School Nurse
65A Associate School Nurse
66 School Psychologist
67 Teacher of the Blind and Visually Impaired
68 Teacher of the Deaf and Hard of Hearing
73 *Career & Technical School Counseling Coordinator
76 Reading/English Language Arts Specialist
78 Reading/English Language Arts Coordinator
80 Early Childhood Special Educator
81 Intensive Special Needs
82 Special Educator
84 Educational Speech Language Pathologist
85 Consulting Teacher
86 Director of Special Education
87 Career and Technical Special Needs Teacher

Endorsement codes listed in bold are considered "professional" for services billed as Developmental and Assistive Therapy

Case Management Assurance

Student Information

Name: John Doe Date of Birth (mm/dd/yy) 2/1/98

Diagnostic Code: 315

Provider Information

Provider Name: James Hill Name of School: Vermont Elementary School

Supervisory Union Name : Vermont Supervisory Union

IEP Services Provided

Enter below the initiation date of the student's IEP and the number of hours per week listed on that IEP for Case Management Services:

IEP Initiation/Amendment Date	IEP Hours Per Week (indicate if service is monthly)
9/15/2008	1
9/15/08 (amended 10/6/08)	1hr per month

Billing Period Assurance

This assurance covers the following dates for the billing period:

From:	10/1/08
To:	10/31/08

I assure that I provided the following number of hours of case management during this billing period.	2 Hours

Provider Signature: _____ **Date**: _____

Case Management Assurance

Student Information

Name: _____ Date of Birth (mm/dd/yy) _____

Diagnostic Code: _____

Provider Information

Provider Name: _____ Name of School: _____

Supervisory Union Name : _____

IEP Services Provided

Enter below the initiation date of the student's IEP and the number of hours per week listed on that IEP for Case Management Services:

IEP Initiation/Amendment Date	**IEP Hours Per Week** (indicate if service is monthly)

Billing Period Assurance

This assurance covers the following dates for the billing period:

From:	
To:	

I assure that I provided the following number of hours of case management during this billing period.	_____Hours

Provider Signature: _____ **Date**: _____

Developmental & Assistive Therapy Service Documentation Log

Student Information

Name: Jane Doe **Date of Birth (Mo/Day/Year):** 2/1/97

Diagnostic Code: 315.9

Provider Information

Provider Name: John Smith **Provider Title:** paraprofessional

Supervisory Union: Vermont SU **Name of School:** Vermont Elementary

IEP Service:

List the activity being provided as it appears on the IEP.

IEP Activity	Individual or Group	Minutes Per Session	Sessions Per Week	Hours Per Week
Reading Skills	**I**	**1hr**	**3**	**3**

Developmental & Assistive Therapy service listed above was provided to this student as shown in the calendar below:

Service Dates: The numbered boxes below reflect the days of the month. Enter month and year for the month(s) of billing period. Mark an "X" for each day that the Developmental and Assistive Therapy service was provided for the minutes and group size listed above. **If the minutes per session or group size are different then what is listed above, the actual minutes per session or group size should be indicated on the calendar**. For services provided in groups, only include those provided in Medicaid billable group size. For professionals, the group size must be six or less students and for paraprofessionals, the group size must be four or less students.
DO NOT USE PENCIL OR WHITE OUT.

Month October Year 2006 Month _____ Year _____

Use this set of dates for a two-month billing period

1	2 X	3	4 X	5	6 X	7	1	2	3	4	5	6	7
8	9 30m	10	11 X	12	13 X	14	8	9	10	11	12	13	14
15	16 30m	17	18 X	19	20 X	21	15	16	17	18	19	20	21
22	23 30m	24	25 X	26	27 X	28	22	23	24	25	26	27	28
29	30 X	31					29	30	31				

Indicate the total number of hours of billable service provided during the billing period:	**1:1 Service**	**11**	**Hours**
	Small Group		**Hours**

Provider Signature: ***John Smith*** **Date:** **11/2/06**

Supervisor Signature: **Jessica Hill** **Date:** **11/2/06**

Supervisor Name (Printed): _____

Developmental & Assistive Therapy Service Documentation Log

Student Information

Name: _____ **Date of Birth (Mo/Day/Year):** _____

Diagnostic Code: _____

Provider Information

Provider Name: _____ **Provider Title:** _____

Supervisory Union: _____ **Name of School:** _____

IEP Service:

List the activity being provided as it appears on the IEP.

IEP Activity	Individual or Group	Minutes Per Session	Sessions Per Week	Hours Per Week

Developmental & Assistive Therapy service listed above was provided to this student as shown in the calendar below:

Service Dates: The numbered boxes below reflect the days of the month. Enter month and year for the month(s) of billing period. Mark an "X" for each day that the Developmental and Assistive Therapy service was provided for the minutes and group size listed above. **If the minutes per session or group size are different then what is listed above, the actual minutes per session or group size should be indicated on the calendar**. For services provided in groups, only include those provided in Medicaid billable group size. For professionals, the group size must be six or less students and for paraprofessionals, the group size must be four or less students.
DO NOT USE PENCIL OR WHITE OUT.

Month _____ Year _____ Month _____ Year _____

Use this set of dates for a two-month billing period

1	2	3	4	5	6	7	1	2	3	4	5	6	7
8	9	10	11	12	13	14	8	9	10	11	12	13	14
15	16	17	18	19	20	21	15	16	17	18	19	20	21
22	23	24	25	26	27	28	22	23	24	25	26	27	28
29	30	31					29	30	31				

Indicate the total number of hours of billable service provided during the billing period:	1:1 Service	Hours
	Small Group	Hours

Provider Signature: _____ **Date:** _____

Supervisor Signature: _____ **Date:** _____

Supervisor Name (Printed): _____

Personal Care Service Documentation Log

Student Information

Name: Jane Doe **Date of Birth (Mo/Day/Year):** 2/1/97

Diagnostic Code: 315.9

Personal Care Hours Per Week: 33 **Does the student receive 1:1 services during their entire school week?** yes

Provider Information

Provider Name: Mary Smith **Provider Title:** Individual Aide

Supervisory Union: Vermont SU **Name of School:** Vermont Elementary School

The student's current IEP requires full-time 1:1 personal care services.

Service Dates: The numbered boxes below reflect the days of the month. **Write the number of hours personal care was provided in the corresponding date box. DO NOT USE PENCIL OR WHITE OUT**.

Month October Year 2006 Month _____ Year _____

Use this set of dates for a two-month billing period

1	2 6hr	3 6hr	4 6hr	5 6hr	6 6hr	7		1	2	3	4	5	6	7
8	9 6hr	10 3hr	11 6hr	12 6hr	13 6hr	14		8	9	10	11	12	13	14
15	16 6hr	17 6hr	18 6hr	19 6hr	20 6hr	21		15	16	17	18	19	20	21
22	23 6hr	24 6hr	25 6hr	26 6hr	27 5hr	28		22	23	24	25	26	27	28
29	30 6hr	31 6hr						29	30	31				

Total hours personal care was provided during the billing period 128 **hours**

Service Type: The 1:1 personal care support for this student includes the following activities. Check all that apply (at least one of the 1 through 9 activities must be checked in order to be considered personal care).

1. ☐ **Assistance w/Eating**
2. ☐ **Assistance w/Toileting**
3. ☐ **Assistance w/Dressing**
4. ☐ **Assistance w/Hygiene**
5. ☒ **Behavior Management**
6. ☐ **Signing/Interpreting**
7. ☐ **Medication Admin.**
8. ☐ **Mobility/Safety**
9. ☐ **Assistive Devices**
10. ☐ **Other:** _____

Provider Signature: *Mary Smith* **Date:** 11/2/06

Supervisor Signature: *Jessica Hill* **Date:** 11/2/06

Supervisor Name (Printed): Jessica Hill

Personal Care Service Documentation Log

Student Information

Name: _____ **Date of Birth (Mo/Day/Year):** _____

Diagnostic Code: _____

Personal Care Hours Per Week: _____ **Does the student receive 1:1 services during their entire school week?** _____

Provider Information

Provider Name: _____ **Provider Title:** _____

Supervisory Union: _____ **Name of School:** _____

The student's current IEP requires full-time 1:1 personal care services.

Service Dates: The numbered boxes below reflect the days of the month. **Write the number of hours personal care was provided in the corresponding date box. DO NOT USE PENCIL OR WHITE OUT**.

Month _____ Year _____ Month _____ Year _____

Use this set of dates for a two-month billing period

1	2	3	4	5	6	7		1	2	3	4	5	6	7
8	9	10	11	12	13	14		8	9	10	11	12	13	14
15	16	17	18	19	20	21		15	16	17	18	19	20	21
22	23	24	25	26	27	28		22	23	24	25	26	27	28
29	30	31						29	30	31				

Total hours personal care was provided during the billing period _____ **hours**

Service Type: The 1:1 personal care support for this student includes the following activities. Check all that apply (at least one of the 1 through 9 activities must be checked in order to be considered personal care).

1. ☐ **Assistance w/Eating**
2. ☐ **Assistance w/Toileting**
3. ☐ **Assistance w/Dressing**
4. ☐ **Assistance w/Hygiene**
5. ☐ **Behavior Management**
6. ☐ **Signing/Interpreting**
7. ☐ **Medication Admin.**
8. ☐ **Mobility/Safety**
9. ☐ **Assistive Devices**
10. ☐ **Other:** _____

_____

_____

Provider Signature: _____ **Date:** _____

Supervisor Signature: _____ **Date:** _____

Supervisor Name (Printed): _____

Vermont Department of Education

Related Services Documentation Log

For professional services including PT, OT, Speech, Language & Hearing, Vision, Nutrition, Mental Health Counseling, Rehabilitative Nursing Services.
Not for use with Developmental and Assistive Therapy or Personal Care Services

STUDENT INFORMATION	**PROVIDER INFORMATION**
Name: James Sinclair	**Provider Name:** Albert Johnson
DOB: 6/12/90	**Provider Type:** RPT
Diagnostic Code: 315.3	**SU/School:** VTSU/Vermont Elem. School

Date mm/dd/yy	Activity/Procedure/Service Brief Description	Small Group Or Individual	Minutes Per Session
9/6/02	Worked on range of motion, R&L legs	Individual	30
9/9/02	Worked on stair climbing	Individual	30
9/13/02	Worked on fine motor coordination	Individual	30
9/16/02	James was absent, missed scheduled appt.		
9/20/02	Worked on stair climbing	Individual	30
9/23/02	Worked on leg ROM	Individual	30
9/26/02	Worked on jumping rope	Individual	30
9/30/02	Worked on leg ROM	Individual	30

Group size must be six or less students for professional services or four or less students for paraprofessional services in order to be a Medicaid billable service. Use additional pages as necessary. **DO NOT USE DITTO MARKS, ARROWS, PENCIL or WHITE OUT**.

Actual hours of 1:1 services provided during the billing period	**3.5 hours**
Actual hours of small group services provided during the billing period	**_____ hours**

Quarterly progress note to be completed on the back of this form.

Provider Signature: Albert Johnson **Date:** 9/30/06

Title: Registered Physical Therapist

Supervisor Signature: _____ **Date:** _____
(Supervisor signature is required if the service above is provided by staff member who is considered a paraprofessional for Medicaid billing purposes.)

Supervisor Name (Printed): _____

Related Services Documentation Log

For professional services including PT, OT, Speech, Language & Hearing, Vision, Nutrition, Mental Health Counseling, Rehabilitative Nursing Services.
Not for use with Developmental and Assistive Therapy or Personal Care Services.

STUDENT INFORMATION	**PROVIDER INFORMATION**
Name: **Date of Birth:** **Diagnostic Code:**	**Provider Name:** **Provider Type:** **SU/School:**

Date mm/dd/yy	**Activity/Procedure/Service Brief Description**	**Small Group Or Individual**	**Minutes Per Session**

Group size must be six or less students for professional services or four or less students for paraprofessional services in order to be a Medicaid billable service. Use additional pages as necessary. **DO NOT USE DITTO MARKS, ARROWS, PENCIL or WHITE OUT**.

Actual hours of 1:1 services provided during the billing period	_____ **hours**
Actual hours of small group services provided during the billing period	_____ **hours**

Quarterly progress note to be completed on the back of this form.

Provider Signature: _____ **Date:** _____

Title: _____

Supervisor Signature: _____ **Date:** _____

Supervisor Name (Printed): _____

The following documents indicate who can complete/change information on the documentation logs.

Color of Cell	Who Can Make Changes.
	Medicaid Clerk, Case Manager, Provider--Can enter information into the cell before the log is signed and can modify information after the log is signed.
	Provider NOTE--if information is changed after the form is signed, the change must be initialed.
	Medicaid Clerk, Case Manager, Provider--Can enter information into the cell before the log is signed. Only the provider can modify information after the log is signed. NOTE--if information is changed after the form is signed, the change must be initialed.

In addition--While it is acceptable to make changes as indicated above, all changes must be reasonable. For example--The Medicaid clerk has the ability to modify the student information on the documentation logs. This does not mean that the Medicaid clerk can change the student's name on the log from Jimmy Smith to Bobby Brown (unless the student's name has actually changed from Jimmy Smith to Bobby Brown). Another example--If a documentation log states "Math" and the IEP service states "Reading", the Medicaid clerk could not change the service on the documentation log to match the IEP as Math and Reading are two different services.

Case Management Assurance

Student Information

Name: Date of Birth (mm/dd/yy)

Diagnostic Code:

Provider Information

Provider Name: Name of School:

Supervisory Union Name :

IEP Services Provided

Enter below the initiation date of the student's IEP and the number of hours per week listed on that IEP for Case Management Services:

IEP Initiation/Amendment Date	IEP Hours Per Week (indicate if service is monthly)

Billing Period Assurance

This assurance covers the following dates for the billing period:

From:	
To:	

I assure that I provided the following number of hours of case management during this billing period.	_____Hours

Provider Signature: _____ **Date**: _____

Developmental & Assistive Therapy Service Documentation Log

Student Information

Name: **Date of Birth (Mo/Day/Year):**

Diagnostic Code:

Provider Information

Provider Name: **Provider Title:**

Supervisory Union: **Name of School:**

IEP Service:

List the service being provided as it appears on the IEP. Add hours per week based on the IEP.

IEP Activity	Individual or Group	Minutes Per Session	Sessions Per Week	Hours Per Week

Developmental & Assistive Therapy service listed above was provided to this student as shown in the calendar below:

Service Dates: The numbered boxes below reflect the days of the month. Enter month and year for the month(s) of billing period. Mark an "X" for each day that the Developmental and Assistive Therapy service was provided for the minutes indicated in the IEP as a session. **If the minutes per session or group size are different then what is listed in the IEP, the actual minutes per session or group size should be indicated on the calendar**. For services provided in groups, only include those provided in Medicaid billable group size. For professionals, the group size must be six or less students and for paraprofessionals, the group size must be four or less students.
DO NOT USE PENCIL OR WHITE OUT.

Month							Year	Month							Year
								Use this set of dates for a two-month billing period							
1	2	3	4	5	6	7		1	2	3	4	5	6	7	
8	9	10	11	12	13	14		8	9	10	11	12	13	14	
15	16	17	18	19	20	21		15	16	17	18	19	20	21	
22	23	24	25	26	27	28		22	23	24	25	26	27	28	
29	30	31						29	30	31					

Indicate the total number of hours of billable service provided during the billing period:	1:1 Service	Hours
	Small Group	Hours

Provider Signature: _____ **Date:** _____

Supervisor Signature: _____ **Date:** _____

Supervisor Name (Printed): _____

Personal Care Service Documentation Log

Student Information

Name: _____ **Date of Birth (Mo/Day/Year):** _____

Diagnostic Code: _____

Personal Care Hours Per Week: _____ **Does the student receive 1:1 services during their entire school week?** _____

Provider Information

Provider Name: **Provider Title:**

Supervisory Union: **Name of School:**

The student's current IEP requires full-time 1:1 personal care services.

Service Dates: The numbered boxes below reflect the days of the month. **Write the number of hours personal care was provided in the corresponding date box. DO NOT USE PENCIL OR WHITE OUT**.

Month Year Month Year

Use this set of dates for a two-month billing period

1	2	3	4	5	6	7		1	2	3	4	5	6	7
8	9	10	11	12	13	14		8	9	10	11	12	13	14
15	16	17	18	19	20	21		15	16	17	18	19	20	21
22	23	24	25	26	27	28		22	23	24	25	26	27	28
29	30	31						29	30	31				

Total hours personal care was provided during the billing period _____ **hours**

Service Type: The 1:1 personal care support for this student includes the following activities. Check all that apply (at least one of the 1 through 9 activities must be checked in order to be considered personal care).

1. ☐ **Assistance w/Eating**
2. ☐ **Assistance w/Toileting**
3. ☐ **Assistance w/Dressing**
4. ☐ **Assistance w/Hygiene**
5. ☐ **Behavior Management**
6. ☐ **Signing/Interpreting**
7. ☐ **Medication Admin.**
8. ☐ **Mobility/Safety**
9. ☐ **Assistive Devices**
10. ☐ **Other:** _____

_____

_____

Provider Signature: _____ **Date:** _____

Supervisor Signature: _____ **Date:** _____

Supervisor Name (Printed): _____

Related Services Documentation Log

For professional services including PT, OT, Speech, Language & Hearing, Vision, Nutrition, Mental Health Counseling, Rehabilitative Nursing Services.
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Date mm/dd/yy	**Activity/Procedure/Service Brief Description**	**Small Group Or Individual**	**Minutes Per Session**

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Quarterly progress note to be completed on the back of this form.

Provider Signature: _____ **Date:** _____

Title: _____

Supervisor Signature: _____ **Date:** _____

Supervisor Name (Printed): _____